

Referral Form

Our Safe Place

3427 4th Ave
 San Diego, CA 92103
 Phone: 619.525.9903
 Fax: 619.525-9908
 Website: www.sdyouthservices.org



Please fax completed form to our clinic at the number listed above (no cover sheet necessary). If you have any questions about our services, please refer to our brochure or contact our clinic.

Potential Clients Info	Legal Last Name	Legal First Name	Legal Middle	Ok to contact parent/guardian?
	Preferred Name		Gender	Gender Pronoun
	Address		Phone Number(s)	Ok to leave VM?
	Social Security #		Email	Date of Birth
	Please select applicable coverage potential client has: <input type="checkbox"/> Medi-Cal Policy ID: _____ <input type="checkbox"/> Other Coverage Name of Insurance: _____ Policy ID: _____ <input type="checkbox"/> No Coverage			
Parent/Legal Guardian Info	Legal Last Name	Legal First Name	Preferred Language	Email Address
	Address <input type="checkbox"/> Same as potential client		Relationship to Client	Phone Number(s)
	Legal Last Name	Legal First Name	Preferred Language	Email Address
	Address <input type="checkbox"/> Same as potential client		Relationship to Client	Phone Number(s)
	Potential client interested in receiving services? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Parent/legal guardian interested in participating in services? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Is Parent/Legal guardian aware of identity/orientation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Referral Info and Consents	Is Parent/Legal guardian supportive of identity/orientation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Reason for referral/additional information:			
	<input type="checkbox"/> Youth is at risk for emergency psychiatric hospitalization as one possible treatment option, though not necessarily the only treatment option or Youth has had at least one emergency psychiatric hospitalization in the past 24 months. Date of hospitalization: _____ <input type="checkbox"/> Early signs of psychosis If yes, please specify: _____			
	Please check all appropriate symptoms: <input type="checkbox"/> auditory/visual hallucinations <input type="checkbox"/> angry/argumentative <input type="checkbox"/> sad/depressed <input type="checkbox"/> anxious <input type="checkbox"/> threat to others <input type="checkbox"/> threat to self <input type="checkbox"/> learning disability <input type="checkbox"/> inattentive <input type="checkbox"/> disruptive <input type="checkbox"/> declining grades <input type="checkbox"/> truancy <input type="checkbox"/> low self-esteem <input type="checkbox"/> social problems <input type="checkbox"/> withdrawn/isolates <input type="checkbox"/> alcohol/substance abuse <input type="checkbox"/> runaway <input type="checkbox"/> divorce/separation <input type="checkbox"/> identity/orientation <input type="checkbox"/> coming out <input type="checkbox"/> suicidal thoughts/attempts			
	Referring person's Name / Organization / Phone / Email:			
	Date of Referral:			
	Potential client's signature and date:			
	Parent's / legal guardian's signature and date:			

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For Office Use Only

SP #: _____

Date Attempted: _____ Outcome: _____

Date Attempted: _____ Outcome: _____

Date Attempted: _____ Outcome: _____

Date Attempted: _____ Outcome: _____

Reason Youth/Family Did Not follow through: _____

Intake Appointment Date/Time/Location: _____

Assigned Staff: _____

Referral Source Updated On: _____